WANT TO AVOID FEELING OR LOOKING LIKE THIS???

Back By Popular Demand!

Make your plans to get your

Flu Vaccine

Woolfolk Building – Room 145

Wednesday

September 30, 2015

1:30 p.m.-4:00 p.m.

Cost – FREE!

(with your State & School Employees' Health Insurance)

Protect yourself. Protect your loved ones.

Get Your Flu Vaccine!

MEA Medical Clinics

Jackson, Mississippi

Protect yourself. Protect your loved ones.

Get Your Flu Vaccine!

Clinic:_____

Patient #_____

Registration Sheet

Date: _____

PATIENT INFORMATION

Please complete full legal name

Patient_____
Last First Middle

Mailing Address _____

_____
City State Zip

Hm.Ph._____ Cell .Ph._____

Work Ph. _____ Employer _____

Employer Address: _____
Street

_____
City State Zip

Social Security # _____

Date of Birth ____/____/_____ Age: _____

Sex: M or F Marital Status: S M D W (circle one)

Email_____

Is visit related to an injury? Yes No (circle one)

Date of Injury_____

Injury: Auto Work Other_____ (circle one)

Race: Asian, African American, Hispanic,
Native American, other, unknown, white (Caucasian)

RESPONSIBLE PARTY INFORMATION

If patient is minor, parent or guardian completing registration sheet

Name_____
Last First Middle

Mailing Address _____

_____
City State Zip

Hm..Ph._____ Cell Ph. _____

Employer Address: _____
Street

Social Security # _____

Date of Birth ____/___/____ Sex: M or F (circle one)

Marital Status: S M D W (circle one)

Work Ph ._____ Employer_____

City State Zip

INSURANCE INFORMATION

PRIMARY

Insurance Company_____

Insured's Name_____
Last First Middle

Address_____

_____
City State Zip

Patient's Relationship to Insured: Self Child Spouse Other

Group # _____ Policy #_____

Effective Date _____

Hm.Ph._____ Wk.Ph._____ Ext. _____

Date of Birth _____ Sex: M or F

Social Security #_____ Employer_____

SECONDARY/SUPPLEMENTAL

Insurance Company _____

Insured's Name_____
Last First Middle

Address_____

_____
City State Zip

Patient's Relationship to Insured: Self Child Spouse Other

Group # _____ Policy _____

Effective Date _____

Hm.Ph._____ Wk.Ph._____ Ext._____

Date of Birth _____ Sex: M or F

Social Security#_____ Employer_____

In Case Of Emergency Contact _____ _____ _____
Name Relationship Phone

Primary Care Physician _____

Method of Payment ( ) Cash ( ) Check ( ) Credit Card

CONSENT FOR TREATMENT

Authorization for treatment, release of medical information and assignment of insurance benefits.

Authorization to Release: I hereby authorize MEA Medical Clinics and any physician providing treatment to me, to release or disclose to insurance companies and/or outpatient benefit programs and their designees all information from my medical record pertaining to my medical treatment as needed to process Insurance claims. I hereby authorize MEA Medical Clinics to obtain prescription history from providers and/or pharmacies.

Authorization to release: Work/School excuse to my employor/school offical should the need arise.

Authorization to Pay Insurance Benefits: I hereby assign payment directly to MEA Medical Clinics of all insurance and similar benefits otherwise payable to me by virtue of medical treatment provided by MEA, but not to exceed MEA Medical Clinic's regular charges for medical treatment. I understand I am financially responsible for charges not covered by insurance, and I hereby agree to be responsible for all charges incurred, regardless of the status of medical insurances or similar benefits.

Consent for Treatment: The undersigned patient or patient's representative authorize(s) the physician(s) on duty at the MEA Medical Clinics to furnish medical and surgical treatment by those means he/she considers necessary and proper in the treatment of the patient identified below while a patient of MEA Medical Clinics. This treatment may require diagnostic procedures including but not limited to laboratory tests, drawing blood for those tests, x-rays and electrocardiograms.

Consent for Retirement of X-Rays Film and Graphic Data: The undersigned authorizes the clinic to retire x-ray films and any other graphic data which may be generated seven years after they are generated if the written and signed findings of a radiologist or other professional who has interpreted the x-ray or graphic data is maintained in the medical record. Exception: Patient is unable to consent because:_____

_____

Payment Terms; Late Fee: I understand that payment in full is due on the date of treatment for all services provided and I agree to pay all charges for the patient named below. If payment in full is delayed for any reason (such as the failure of my insurance to pay the balance in full), I agree to pay the full balance. On any balance remaining more than fifteen (15) days after the date of service, I also agree to pay a late fee that is the GREATER of five dollars ($5.00) or four percent (4%) of the unpaid balance.

Valuables: The undersigned hereby releases the MEA Medical Clinics and/or its staff of employees from any responsibility due to loss or damage of any valuables that the patient may keep in his/her possession or that may be brought to him/her by other persons while on the premises of the MEA Medical Clinics.

Printed Patient Name	Signature Patient/Guardian (if minor)	Date

MEA MEDICAL CLINICS

INFLUENZA VACCINATION CONSENT FORM

Name: _____ Date of Birth: _____ Age: _____
(Last) (First)

Address: _____ City: _____ State: _____

Company: _____ Work Phone: _____ Home Phone: _____

	Yes	No
Do you have a severe allergy to egg products?	_____	_____
Do you have an active neurologic disorder (MS, Parkinson's, ALS, etc.)?	_____	_____
Have you ever been paralyzed with Gullain-Barre Syndrome secondary to the flu vaccine?	_____	_____
Are you currently ill, have a fever or are you on antibiotics?	_____	_____
Do you have a history of allergy to mercury products?	_____	_____
Do you have an aminoglyside allergy? (Gentimycin/Mycin) antibiotics	_____	_____
Have you had a previous flu vaccination this year? (Adults receive one dose)	_____	_____
Do you have a known or suspected pregnancy?	_____	_____
Have you received another type of vaccine within the last 14 days?	_____	_____

If you have any questions about the influenza vaccination information you have read or anything on this form, please ask the healthcare personnel administering the injections. If you answered "yes" to any of the above questions, we recommend that you consult with your personal physician before receiving the influenza vaccine.

Have you had an influenza vaccination in the past?	_____	_____
Have you ever had a problem taking the influenza vaccine?	_____	_____

Briefly describe the problem _____

I understand that the vaccination is being provided by MEA Medical Clinics. I expressly release from any liability the above organization and individual giving the influenza vaccine. I, for myself, my heirs, executors, assigns hereby agree to release MEA and its employees from any and all claims arising out of, in connection with, or in any way related to my receipt of this influenza vaccine.

I understand the benefits and risks of the influenza vaccination as described. I request that the influenza vaccination be given to me.
I agree to remain in the area for at least 15 minutes for observation.

Signature: _____ Date: _____

Manufacturer: _____ Lot #: _____ Exp. Date: _____

Dose: 0.5cc IM Injection site: R/L deltoid Signature: _____ Title: _____

VIS dated: 08/07/15 given to patient

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

MEA Medical Clinics

Designated Privacy Official: (601) 898-7526

I HEREBY ACKNOWLEDGE THAT I HAVE RECEIVED AND REVIEWED A COPY OF MEA MEDICAL CLINIC'S NOTICE OF PRIVACY PRACTICES.

Patient Name (please print):_____ Date:_____

Patient Signature:_____ Telephone: _____

If not signed by the patient, please indicate relationship:

- ☐ Parent or guardian of minor patient
- ☐ Guardian or conservator of an incompetent patient
- ☐ Beneficiary or personal representative of deceased patient
- ☐ Other (specify) _____

For Office Use Only:

- MEA staff signature or initials & date:_____
- Acknowledgment refused: Efforts to obtain:

Efforts to obtain:

_____

_____

Reasons for refusal:

_____

_____

NOTE: Please file in patient chart under most recent registration sheet.